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No. _____

In The
Supreme Court of the United States

THERESA NOREN,

Petitioner

v.

JEFFERSON PILOT FINANCIAL INSURANCE COMPANY,

Respondents

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

APPENDIX TO THE PETITION FOR A WRIT OF CERTIORARI

Steven P. Krafchick
Counsel of Record
Krafchick Law Firm
100 West Harrison
South Tower, Suite 300
Seattle, WA 98119
klf@krafchick.com
(206) 374-7372

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klf@krafchick.com
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UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

THERESA NOREN, Plaintiff-Appellant,

v.

JEFFERSON PILOT FINANCIAL INSURANCE COMPANY, formerly a Nebraska Corporation; et al., Defendants-Appellees.

No. 09-35242

ORDER

June 29, 2010, Filed

Before: GOODWIN, HAWKINS and N.R. SMITH, Circuit Judges.

Judge N.R. Smith has voted to deny the petition for rehearing en banc, and Judges Goodwin and Hawkins have so recommended.

The full court was advised of the petition for rehearing en banc and no judge has requested a vote on whether to rehear the matter en banc. Fed.R.App.P. 35.

The petition rehearing en banc is DENIED.

NOT FOR PUBLICATION

UNITED STATES COURT
OF APPEALS FOR THE
NINTH CIRCUIT

THERESA NOREN,
Plaintiff-Appellant,

v.

JEFFERSON PILOT
FINANCIAL INSURANCE
COMPANY, formerly a
Nebraska Corporation; et
al., Defendants-Appellees.

No. 09-35242

MEMORANDUM*

May 10, 2010, Filed

Appeal from the United States District Court
For the Western District of Washington
Richard A. Jones, District Judge, Presiding

Submitted April 7, 2010**
Seattle, Washington

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* This disposition is not appropriate for publication and is not precedent except as provided by 9th Cir. R. 36-3.

** The panel unanimously finds this case suitable for decision without oral argument. *See* Fed. R. App. P. 34 (a)(2).

Before: GOODWIN, HAWKINS and N.R. SMITH, Circuit Judges.

The district court correctly applied the prudential exhaustion doctrine in granting Jefferson Pilot's motion for summary judgment. The facts of this case are familiar to the parties and we need not recite them here.

ERISA does not explicitly require a participant to exhaust available internal review before bringing a claim in federal court. *See* 29 U.S.C. § 1132; *Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620, 625-26 (9th Cir. 2008). However, we "long ago concluded that 'federal courts have authority to enforce the exhaustion requirement in suits under ERISA, and that as a matter of sound public policy they should usually do so.'" *Vaught*, 546 F.3d at 626 (quoting *Amato v. Bernard*, 618 F.2d 559, 568 (9th Cir. 1980)). It is undisputed that 1) the plans in this case required two levels of internal administrative review and 2) Noren failed to file a second appeal. Thus, absent an applicable exception, Jefferson Pilot's motion for summary judgment was properly granted under the prudential exhaustion doctrine.

There are three exceptions to the prudential exhaustion doctrine: 1) futility; 2) inadequate remedy; and 3) unreasonable procedures. *See Vaught*, 546 F.3d at 626–27. None of these exceptions help Noren's case.

Noren argues that, once her first appeal was rejected, 1) she did not know what further

information she could submit to influence Jefferson and 2) a second appeal would thus have been futile. The claimant's bare assertion that she does not think her appeal will be successful does not demonstrate futility. *See Diaz v. United Agric. Employee Welfare Benefit Plan & Trust*, 50 F.3d 1478, 1485 (9th Cir. 1995) (rejecting a nearly identical argument).

Likewise, bare assertions are insufficient to establish the applicability of the inadequate remedy exception. Rather, this exception applies when the procedure is demonstrably inadequate or tainted by personal bias. *See Amato*, 618 F.2d at 569. Noren's only specific argument relating to inadequate procedure is that, because the letter denying her appeal did not specifically state a second appeal was required, the procedures for appeal were too vague and therefore inadequate. This argument is without merit. The appeal procedure was fully contained in the plan information, and no ERISA regulation requires that the appeals process also be outlined in denial letters. *See Diaz*, 50 F.3d at 1484-85 (rejecting an argument that a denial letter in English, which the claimant could not understand, was inadequate when the claimant had a full copy of the applicable plan in Spanish).

We have also recognized that, under 29 C.F.R. § 2560.503-1(*l*), if a plan fails to provide reasonable claims procedures, the claimant will be deemed to have exhausted her required administrative appeals. Under this theory, Noren alleges Jefferson violated ERISA requirements in a number of areas and, therefore, did not provide or

follow reasonable procedures. We need not determine if these violations amount to unreasonable procedures. Noren may have raised some of these violations before the district court, but she did not argue that the alleged violations excused her from exhausting her administrative remedies under 29 C.F.R. § 2560.503-1(*l*). As it is presented for the first time on appeal, this argument is waived. *See Singleton v. Wulff*, 428 U.S. 106, 120 (1976).

Accordingly, we AFFIRM the district court.

Noren v. Jefferson Pilot Financial Insurance Company, No. 09-35242

HAWKINS, Circuit Judge, dissenting:

The majority holds that although Noren raised possible ERISA violations below, she did not raise the arguments explicitly as an excuse for exhausting her administrative remedies. Noren's response to Jefferson Pilot's motion for summary judgment described Jefferson's alleged violations of ERISA procedures, *see* 29 C.F.R. § 2560.503-1(g)(1)(v)(A), (h)(2)(iii)-(iv), (i)(5), (j)(5)(i), (*l*), (m)(8), and then stated as follows:

> Jefferson Pilot's procedural failures have prevented claimant from understanding what the failures were in Plaintiff's claim. Without knowing the shortcomings of the material submitted on appeal, it was useless to submit anything further, if indeed there was even anything further to submit.

Noren has therefore preserved her claim that Jefferson Pilot's ERISA violations prevented her administrative exhaustion. *See In re E.R. Fegert, Inc.*, 887 F.2d 955, 957 (9th Cir. 1989). Since the entirety of the district court's analysis of whether Noren was excused from exhaustion was to note that she was not "excused from doing so," I would remand for the district court to develop the record as to this claim and its application to the ERISA regulations in the first instance.

UNITED STATES DISTRICT COURT WESTERN DISTRICT OF WASHINGTON AT SEATTLE

THERESA NOREN, Plaintiff,

v.

JEFFERSON PILOT FINANCIAL INSURANCE COMPANY, et al., Defendants.

No. C09-0034RAJ

ORDER

March 2, 2009, Filed

I. INTRODUCTION

This matter comes before the court on Defendants' motion for summary judgment (Dkt. # 18). The court has considered the parties' briefing and supporting evidence, and has heard from the parties at oral argument. For the reasons explained below, the court GRANTS Defendants' motion.

II. BACKGROUND

Plaintiff Theresa Noren was formerly employed by Defendant Cartoys, Inc. ("Cartoys"). As a Cartoys employee, Noren was covered by Cartoys' group short-term and long-term disability insurance policies purchased for the benefit of its employees.

In June 2005, Noren filed a short-term disability claim with Defendant Jefferson Pilot Financial Insurance Company ("Jefferson Pilot") due to cervical disc degeneration and fibromyalgia. Jefferson Pilot denied the claim.

Noren's employment was terminated in August 2005. In August 2006, Noren appealed Jefferson Pilot's claim denial. In November 2006, Jefferson Pilot affirmed its denial of Noren's claim. *See* Haushild Decl. (Dkt. # 17), Ex. 10. The denial letter stated:

> As a reminder, you have exhausted your first level of appeal. If you disagree with this decision you may pursue your second and final level of appeal to the Jefferson Pilot Appeals Council. Please be sure to include with your letter of appeal addressed to the Jefferson Pilot Appeals Council, all medical records from your attending or other physicians that you would like to have considered for review.
>
> You or your authorized representative may request a review of your denied claim. Such request must be made in writing and

> submitted to us at the address below within 180 days after you receive this denial notice.
> . . .
>
> Please include your reason(s) for appealing and provide any proof documentation, such as office notes, laboratory results, x-rays and any other testing results to support your appeal. We will then provide you with a full written explanation of the decision within 45 days of receipt of your appeal.

Haushild Decl., Ex. 10. In response to that denial, Noren requested various documents from Jefferson Pilot, and requested 180 days from the date of receipt of those documents to submit additional information in support of her claim. *See id.*, Ex. 11. Jefferson Pilot sent some documents to Noren in December 2006. *See id.*, Ex. 12. Noren never requested a second appeal.

Noren filed this lawsuit in January 2008, and Defendants have now moved for summary judgment.

III. ANALYSIS

A. Standard of Review on Summary Judgment.

Summary judgment is appropriate if there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). The moving party bears the initial burden of demonstrating the absence of a genuine issue of material fact. *Celotex Corp. v. Catrett*, 477

U.S. 317, 323 (1986). Once the moving party meets that initial burden, the opposing party must then set forth specific facts showing that there is a genuine issue of fact for trial in order to defeat the motion. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250 (1986).

B. The Defendants are Entitled to Judgment as a Matter of Law Due to Plaintiff's Failure to Exhaust her Administrative Remedies.

This is an action to recover benefits under group short-term and long-term disability insurance policies under the Employee Retirement Income Security Act of 1974 ("ERISA"). Both the short-term and long-term policy plans at issue in this case include the following provision:

> **Claims subject to ERISA.** Before bringing a civil legal action under the federal law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under this Policy, the plan participant or beneficiary must first seek two administrative reviews of the adverse claims decision, in accord with this section. After the required reviews:
>
> 1. An ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
> 2. The Company will waive any right to assert that he or she failed to exhaust administrative remedies.

Haushild Decl., Ex. 1 at 25 and 47. Consistent with this two-appeal plan requirement, the November 3 denial letter told Noren how to obtain a second appeal. *See id.*, Ex. 11. Though Noren's response requested an extension of time in which to request an appeal, Noren never actually filed a second appeal.

This failure is fatal to Noren's ability to seek relief from this court. As the Ninth Circuit recently instructed:

> [B]ased on both the text of ERISA and its legislative history, we long ago concluded that 'federal courts have the authority to enforce the exhaustion requirement in suits under ERISA and that as a matter of sound policy they should usually do so.' *Amato v.* Bernard, 618 F.2d 559, 568 (9th Cir. 1980). Accordingly, we have consistently held that before bringing suit under § 502 [of ERISA], an ERISA plaintiff claiming a denial of benefits 'must available himself or herself of a plan's own internal review procedures before bringing suit in federal court.' *Diaz v. United Agric. Employee Welfare Benefit Plan & Trust*, 50 F.3d 1478, 1483 (9th Cir. 1995).

Vaught v. Scottsdale Healthcare Corp. Health Plan, 546 F.3d 620, 626 (9th Cir. 2008). Though not a jurisdictional requirement, this prudential exhaustion requirement "serves several important

policy considerations, including the reduction of frivolous litigation, the promotion of consistent treatment of claims, the nonadversarial method of claims settlement, the minimization of costs of claim settlements, and a proper reliance on administrative expertise." *Diaz*, 50 F.3d at 1483.

At oral argument, Noren's counsel agreed that the insurance plans include an explicit two-appeal process. Counsel contended that Noren completed this process, due to the indication in her response to the first appeal denial that she intended to file a second appeal within 180 days of receiving requested documents. But an indication of intent to file a second appeal is not the same as the filing of a second appeal. Counsel argued that Jefferson Pilot could have independently conducted a second appeal, but cited no authority obligating it to do so. Counsel's attempt to shift the burden to Jefferson Pilot to conduct claims appeals, in the absence of a request from a claimant, is unavailing.

Counsel also contended at oral argument that the denial letter from Jefferson Pilot did not explicitly inform Noren that failure to file a second appeal would prevent her from filing a civil action. But again, counsel has not cited any authority requiring that this information be included in a denial letter. The plan clearly states the two-appeal process, and Noren does not claim she did not have notice of that process.

Thus, because it is undisputed that the plans at issue required Noren to file two appeals before filing a civil action, and because she has not shown

that she did not seek two appeals or should be excused from doing so, the court concludes that Noren failed to exhaust the administrative remedies available under the plans at issue. Based on the prudential exhaustion requirement, the Defendants are entitled to judgment as a matter of law.

IV. CONCLUSION

For the foregoing reasons, the court GRANTS Defendants' motion (Dkt. #16).IT IS SO ORDERED.

DATED this 2nd day of March, 2009.

/s/ Richard A. Jones
The Honorable Richard A. Jones
United States District Judge

Title 29, United States Code, Section 1104(a)(1):

"Subject to sections 403(c) and (d), 4042, and 4044 [29 USCS §§ 1103(c), (d), 1342, 1344], a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this title and title IV".

Title 29, United States Code, Section 1133(1) – (2):

"In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits

under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim".

Title 29, Code of Federal Regulations, Section 2520.102-3:

Contents of summary plan description.

...**The summary plan description *must* accurately reflect the contents of the plans** ... The following information ***shall be included*** in the summary plan description of both employee welfare benefit plans and employee pension benefit plans, except as stated otherwise in paragraphs (j) through (n):

(j) The plan's requirements respecting eligibility for participation and for benefits.....

* * *

2) For employee welfare benefit plans, it shall also include a statement of the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits....

* * *

(l) For both pension and welfare benefit plans, a statement clearly **identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset,**

> **reduction...of any benefits** that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits required by paragraphs (j) and (k) of this section. ... The foregoing summaries shall be disclosed in accordance with the requirements under 29 C.F.R. § 2520.102-2(b).

Title 29, Code of Federal Regulations, Section 2560-503-1(a):

"Scope and purpose. In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act".

Title 29, Code of Federal Regulations, Section 2560-503-1(b)(1-3), (b)(5):

"Obligation to establish and maintain reasonable claims procedures. Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The

claims procedures for a plan will be deemed to be reasonable only if –

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

(2) A description of all claims procedures (including, in the case of a group health plan within the meaning of paragraph (m)(6) of this section, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures) and the applicable time frames is included as part of a summary plan description meeting the requirements of 29 CFR 2520.102-3;

(3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. ...

(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants".

Title 29, Code of Federal Regulations, Section 2560-503-1(c)(2):

"Group health plans. (2) The claims procedures do not contain any provision, and are not administered in a way, that requires a claimant to

file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of the Act"

Title 29, Code of Federal Regulations, Section 2560-503-1(f):

"Timing of notification of benefit determination. (1) In general. Except as provided in paragraphs (f)(2) and (f)(3) of this section, if a claim is wholly or partially denied, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan, unless the plan administrator determines that special circumstances require an extension of time for processing the claim". ...

Title 29, Code of Federal Regulations, Section 2560-503-1(f)(3):

"Disability claims. In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the

circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this paragraph (f)(3), the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information".

Title 29, Code of Federal Regulations, Section 2560-503-1 (g)(1)(iv)-(v)(a):

"Manner and content of notification of benefit determination. (1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant --

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims;

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request".

Title 29, Code of Federal Regulations, Section 2560-503-1 (h)(2)(iii)-(iv):

"Appeal of adverse benefit determinations.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures –

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other

information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination".

Title 29, Code of Federal Regulations, Section 2560-503-1 (h)(4):

"Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section".

Title 29, Code of Federal Regulations, Section 2560-503-1(i)(5):

"Timing of notification of benefit determination on review. ...

(5) Furnishing documents. In the case of an adverse benefit determination on review, the plan administrator shall provide such access to, and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate".

Title 29, Code of Federal Regulations, Section 2560-503-1(j)(2)-(3) and (5)(i):

"Manner and content of notification of benefit determination on review. The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant –

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section"

(5) In the case of a group health plan or a plan providing disability benefits -- (i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request";

Title 29, Code of Federal Regulations, Section 2560-503-1(*l*):

"Failure to establish and follow reasonable claims procedures. In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim".

Title 29, Code of Federal Regulations, Section 2560-503-1(m)(4) – (5) and (8)(iv):

"Definitions. The following terms shall have the meaning ascribed to such terms in this paragraph (m) whenever such term is used in this section:

(4) The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or

service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(5) The term "notice" or "notification" means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b-1(b) as appropriate with respect to material required to be furnished or made available to an individual.

(8) A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information.

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination".

EXCERPT FROM JEFFERSON PILOT SUMMARY PLAN DESCRIPTION:

Claims Procedures. You may obtain claim forms and instructions for filing claims from the Plan Administrator or from the Home Office of Jefferson Pilot Financial Insurance Company. To expedite the processing of your claim. instructions on the claim form should be followed carefully; be sure, all questions are answered fully. In accordance with ERISA, Jefferson Pilot Financial Insurance Company will send you a written notice of its claim decision within:

- 45 days after receiving the first proof of a claim for disability benefits (105 days under special circumstances).

If a claim is partially or wholly denied, this written notice will explain the reason(s) for denial, how a review of the decision may be requested, and whether more information is needed to support the claim. You may request a review of the claim by making a written request to Jefferson Pilot Financial Insurance Company within:

- 180 days after receiving a denial notice of a claim for disability income benefits.

This written request for review should state the reasons why you feel the claim should not have been denied and should include any additional documentation to support your claim. You may also submit tor consideration additional questions or comments you feel are appropriate, and you may review certain non-privileged information relating to the request for review. Jefferson Pilot Financial Insurance Company will make a full and fair review of the claim and provide a final written decision to

you within:

- 45 days after receiving the request for review of a claim for disability income benefits (90 days under special circumstances).

If more information is needed to resolve a claim, the information must be supplied within 45 days after requested. Any resulting delay will not count toward the above time limits for claims or appeals processing. Please refer to your certificate of insurance for more information about how to file a claim, how to appeal a denied claim, and for details regarding the claims procedures.

EXCERPT FROM JEFFERSON PILOT SHORT TERM WEEKLY DISABILITY POLICY:

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section. After the required reviews:

(1) an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and

(2) the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

EXCERPT FROM JEFFERSON PILOT LONG TERM DISABILITY POLICY:

REVIEW PROCEDURE. Within 180 days after receiving a denial notice, the Insured Employee may request a claim review by sending the Company:

1. a written request; and
2. any written comments or other items to support the claim.

The Insured Employee may review claim non-privileged information relating to the request for review.

The Company will review the claim and send the Insured Employee a written notice of its decision. The notice will state the reasons for the Company's decision, under the terms of this Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:

1. any further appeal procedures available under this Policy;
2. the right to access relevant claim information; and
3. the right to request a state insurance department review, or to bring legal action.

This notice will be sent within 45 days after the Company receives the request for review, or within 90 days if a special case requires more time.

Delay Notice. If the Company needs more than 45 days to process an appeal, in a special case:

1. an extension of up to 45 more days will be permitted; and

2. the Company will send the Insured Employee a written delay notice, by the 30th day after receiving the request for review.

The notice will explain:

1. the special circumstances which require the delay;
2. whether more information is needed to review the claim; and
3. when a decision can be expected.

Exception: The Company may need more information from the Insured Employee to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under this Policy, the plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section. After the required reviews:

1. an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
2. the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

EXCERPT FROM KRAFCHICK LAW FIRM LETTER TO JEFFERSON PILOT FINANCIAL DATED NOVEMBER 15, 2005:

... If you contend that this claim is governed by ERISA, please identify the plan administrator (name, address, phone number, fax number) and provide a copy of the Summary Plan Description or tell us the name, phone and fax numbers, and address of the person to contact to get the SPD. Also provide a copy of the insurance policy or policies applicable to our client's claim for disability benefits and a copy of Form 5500 filed with the Department of Labor.

In particular, if you believe this plan is governed by ERISA, we also request a copy of all documents, records, and other information relevant to our client's claim for benefits pursuant to 29 CFR 2560.503-1. This should include all documents, records or other information that was relied upon in making the benefit determination; that was submitted, considered, or generated in the course of making the benefit determination without regard to whether such document, record, or other information was relied upon in making the benefit determination; that demonstrates compliance with required administrative processes or safeguards; or that constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for our client's diagnosis, whether or not it was relied on in making the benefit determination.

Furthermore it should include any internal rule, guideline, protocol, or other similar criterion applicable to handling of this claim.

Whether or not you contend this claim is governed by ERISA, we also request that you tell us the amount of the monthly short term and long term disability benefits our client will be entitled to if eligibility for benefits is established under the applicable policy or plan. Please let us know if there are any cost of living adjustments or other income deductions that you believe would apply.

Very truly yours,

/s/ Steven P. Krafchick
Steven P. Krafchick
Attorney

EXCERPT FROM JEFFERSON PILOT FINANCIAL LETTER DATED DECEMBER 12, 2005 TO KRAFCHICK LAW FIRM:

We are in receipt of your letter dated 11/15/05 regarding your client, Theresa Noren. Please direct all future correspondence to my attention as I will be handling Ms. Noren's appeal, when submitted, for Short Term disability benefits. The above claim number is correct and to date, your client has not been paid any benefits.

In response to your question regarding the decision made by the benefit specialist, it appears that she relied on the Presley Reid Medical Disability Advisor in making her decision. Please be assured that we will provide a full, fair and complete review of your client's claim on appeal, including a thorough review of her medical records.

Enclosed is a copy of Ms. Noren's Short Term disability claim file. I've also included a copy of the Short Term Disability policy issued to Ms. Noren's employer and the Summary Plan Description. The plan administrator and plan sponsor is Car Toys, Inc. The address is 20 West Galer, Seattle, WA 98119. The phone number is (206) 443-0980.

Please be advised that there were no other specific criteria utilized in assessing this claim. A determination of disability is based upon the terms of the contract and whether or not the medical records support the policy provisions for partial or total disability. Each claim is unique and is reviewed on its own merits. We rely on policy language and

ERISA regulations to ensure compliance in making our benefit determination.

...

Sincerely,

/s/ Lisa Koch
Lisa Koch
Disability Appeals Specialist

JEFFERSON PILOT FINANCIAL ADVERSE BENEFIT DECISION, LETTER DATED NOVEMBER 3, 2006:

We have completed our review of Ms. Noren's Short Term Disability appeal. Based on the information provided, we have determined that we are unable to approve benefits. In our appeal review process, all information previously submitted as well as any new documentation is used to make a determination.

To be eligible for benefits under the policy issued to Ms. Noren's employer, an individual must satisfy all of the provisions of the policy. This includes, but is not limited to, the following:

OWN OCCUPATION or REGULAR OCCUPATION means the occupation, trade or profession:
(1) in which the Insured Person was employed with the Employer prior to Disability; and
(2) which was his or her main source of earned income prior to Disability.

It means a collective description or related jobs, as defined by the U.S. Department of Labor Dictionary of Occupational Titles. It includes any work in the same occupation for pay or profit, regardless of:
(1) whether such work is with the Employer, with some other firm, or on a self-employed basis; or
(2) whether a suitable opening is currently available with the Employer or in the local labor market.

TOTAL DISABILITY or TOTAL DISABLED means the Insured Person's inability, due to Sickness or Injury, to perform each of the Main Duties of his or

her Own Occupation. A person engaging in any employment for wage or profit is not Totally Disabled. The loss of a professional license, an occupational license or certification, or a driver's license for any reason does **not**, by itself, constitute Total Disability.

According to the attending physician statement completed by Dr. Scott Pollack on 7/15/2005 Ms. Noren was unable to continue working as a wireless planner beyond 6/22/2005 due to fibromyalgia, migraines and cervical disc disease. As you know Ms. Noren's claim was denied short-term disability benefits on 7/27/2005.

Medical records we have received from Dr. Engel dated 3/28/2005 note the x-rays of her neck show multilevel degenerative disc disease to a moderate degree at C3-4, C4-5 and C5-6. No signs of spondylolisthesis or other abnormalities were noted. The physical exam showed full Shoulder motion, normal strength and mild tenderness at C3-6 and L4-S1. Dr. Engel's notes do not note any nerve involvement and he notes her neuromuscular and motor functions are intact to the hands as well as her feet. She was recommended conservative treatment of physical therapy and anti-inflammatory medication.

Records from Therapeutic Associates dated 4/19/2005 note Ms. Noren was taking part in physical therapy for cervical and thoracic pain. Ms. Noren notes that medication does relieve her symptoms. The last dated therapy note was dated 5/5/2005 and stated that, "The patient report feels

good that exercises are progressing slowly, not hurting after PT visit, except after last visit her shoulder was very irritated". The plan was to continue with therapy, however, we were not provided with these records.

Office notes dated 6/23/2005 from Dr. Scott Pollock note Ms. Noren increased her Mirapex on 6/19/2005 and became violently ill at work. Since that incident she discontinued the medication and had not suffered the side effects. Dr. Pollock noted on 6/28/2005 that you had an IBS flare and were unable to function at work or get out of bed. Ms. Noren was prescribed on 7/15/2005 Ms. Noren begin gentle aerobics.

It is understood that fibromyagia is generally a chronic syndrome, which has periods of waxing and waning the normal recovery period from a flare would be 3-7 days. The medical records support that while she was complaining of neck pain Ms. Noren was able to continue to work while receiving her conservative treatment of physical therapy and medication. The records show the claimant became ill due to an increase in her medication and the symptoms resolved.

In summary, the medical documentation does not support a condition that would render Ms. Noren unable to perform her occupation and does not support a total disability.

As a reminder, you have exhausted your first level of appeal. If you disagree with this decision you may pursue your second and final level of appeal to the

Jefferson Pilot Appeals Council. Please be sure to include, with your letter of appeal addressed to the Jefferson Pilot Appeals Council, all medical records from your attending or other physicians that you would like to have considered for review.

You or your authorized representative may request a review of your denied claim. Such request must be made in writing and submitted to us at the address below within 180 days after you receive this denial notice

Risk Services – Employee Care Center
Jefferson Pilot Financial Insurance Company
PO Box 2337
Omaha, NE 68114

Please include your reason(s) for appealing and provide any proof documentation, such as office notes, laboratory results, x-rays and any other testing results to support your appeal. We will then provide you with a full written explanation of the decision within 45 days of receipt of your appeal.

Please be sure to include your policy number and claim number. If you wish, you may also submit your comments and views of the issues in writing, and may request copies of the pertinent documents.

If your plan is subject to ERISA, you and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local US Department of Labor Office and your State insurance regulatory agency. In addition, once all

required reviews of your claim have been completed; you have the right to bring a civil action under applicable law.

Please contact our office with any questions you may have at the number listed above.

Sincerely,

Kathryn Cave / JSR
Risk Technical Specialist

EXCERPT FROM KRAFCHICK LAW FIRM LETTER DATED NOVEMBER 6, 2006 TO KATHRYN CAVE OF "BENEFITS PARTNERS" RE: JEFFERSON PILOT PLAN BENEFITS DENIAL:

...In our initial letter of representation, dated November 15, 2005, we requested that you provide the documentation upon which you base your claim that the "usual and customary recovery period for your disability is 3-7 days for fibromyalgia and 1 day for a migraine headache." We noted that the statement you made in your July 27, 2005 letter regarding the usual and customary recovery periods for fibromyalgia and migraines came as somewhat of a surprise. We requested that you provide the internal policies and procedures, medical literature, medical opinions, evaluations, and all other information that you relied on for this highly questionable statement.

In response, Ms. Koch sent a letter dated December 12, 2005, stating tht the benefit specialist responsible for this bizarre statement "relied on the **Presley Reid Medical Disability Advisor** in making her decision." While Ms. Koch did provide us with the source of this questionable statement she failed to adequately address our request and provide the actual documents. We once again request that Jefferson Pilot immediately provide a copy of the **Presley Reid Medical Disability Advisor** and the internal policies, procedures, medical literature, medical opinions, evaluations, and all other information that apply to this claim.

...

Also, since you believe this plan is governed by ERISA, we also request a copy of all documents, records, and other information relevant to our client's claim for benefits pursuant to 29 CFR 2560.503-1. This should include all documents, records or other information that was relied upon in making the benefit determination; that was submitted, considered, or generated in the course of making the benefit determination without regard to whether such document, record, or other information was relied upon in making the benefit determination; that demonstrates compliance with required administrative processes or safeguards; or that constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for our client's diagnosis, whether or not it was relied on in making the benefit determination. Furthermore, it should include any internal rule,l guideline, protocol, or other similar criterion applicable to handling of this claim.

Whether or not you contend this claim is governed by ERISA, we also request that you tell us the amount of the monthly benefit our client will be entitled to if eligibility for benefits is established under the applicable policy or plan. ...

We hereby request that you provide us with one hundred eighty (180) days from our receipt of the requested complete administrative record to submit additional information in support of our client's claim. If we do not hear from you to the contrary within fourteen (14) days we will consider that as an agreement to this extension request.

Very truly yours,

/s/ Steven P. Krafchick
Steven P. Krafchick
Attorney

APPEAL WORKSHEET

APPEAL WORKSHEET*

Claimant's Name: Teresa Noren

Initial Claim Info

1st Appeal Info

1st Appeal received: 5/30/06
Review to be done by: LAK

2nd Level Appeal / Appeal Counsel
2nd Appeal received ~~11/6/06~~ [THE DATE IS HANDWRITTEN AND CROSSED OUT]

Review to be done by: MYB

* The appeal worksheet is a form. The entries are handwritten. We have provided what is legible.